BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

DRAFT Joint Forward Plan

Summary of JFP Material
March 2023

Our System Landscape

Our health and care landscape

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

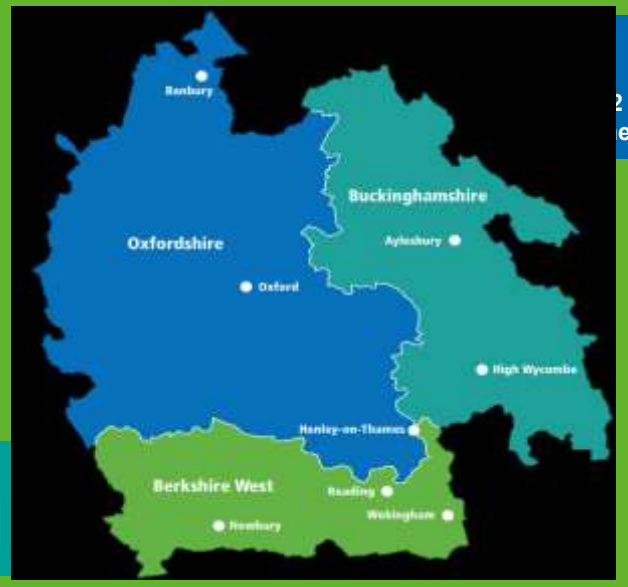
- 159 GP practices
- Thames Valley Cancer Alliance (TVCA)
- Over 250 care homes
- 182 dental practices
- Approx. 260 pharmacies
- 5 Healthwatch organisations
- More than 800 schools
- 5 universities
- 5 unitary / upper tier local authorities
- 5 District Councils
- 8,000 registered social enterprise organisations and estimated that there are over 5,000 informal social enterprise organisations

Our unitary / upper tier councils

Reading Borough Council · West Berkshire Council · Oxfordshire County Council · Buckinghamshire Council · Wokingham Borough Council

Population of nearly 2 million

Approx. 68,000 staff in health and care



50+ primary care networks

2 Community and mental health trusts

- NHS Oxford Health NHS Foundation Trust
- NHS Berkshire Healthcare NHS Foundation Trust

3 Acute/integrated hospital trust

- NHS Royal Berkshire NHS Foundation Trust
- NHS Buckinghamshire Healthcare NHS Trust
- NHS Oxford University Hospitals NHS Foundation Trust

Ambulance trust

- NHS South Central Ambulance Service NHS Foundation Trust

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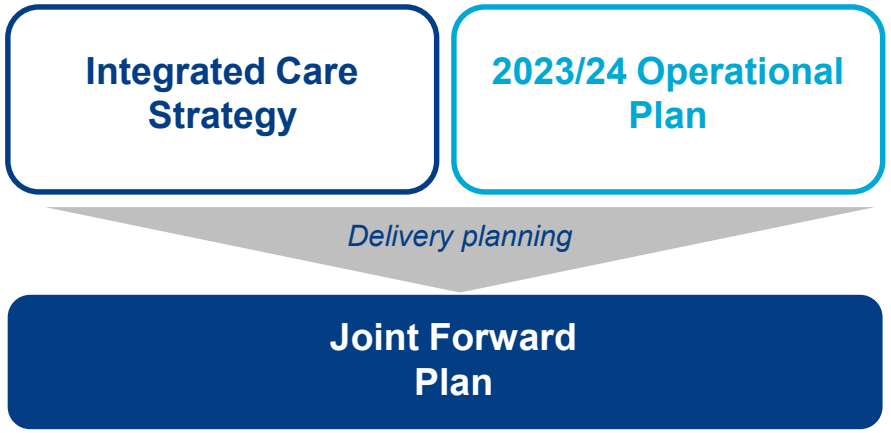
Purpose of the Joint Forward Plan

What is our Joint Forward Plan and what is it for?

Our Joint Forward Plan (JFP) will describe how we intend to deliver the ambition of the **Buckinghamshire, Oxfordshire and Berkshire West (BOB)** Integrated Care Strategy. It also sets out how we will deliver national NHS commitments and recommendations, including the requirements of the 2023/24 operational plans.



This will be our first JFP since the BOB Integrated Care Board (ICB) was formally established on 1 July 2022. It is an opportunity for the ICB and its partner trusts to set out how we will arrange and/or provide NHS services to meet our population's physical and mental health needs. This JFP therefore sets out our five-year comprehensive plan to improve and transform our services, whilst also recognising our most immediate priorities for the year ahead.

This plan will be updated annually before the start of each financial year. We will review the plan regularly, and use it as the basis for monitoring our progress as an Integrated Care System (ICS). Assuring delivery of the Joint forward plan will be picked up formally through the ICB Board and relevant Board assurance committees.

This plan focuses on actions that will be delivered by the ICB and NHS Trusts in BOB. As we develop as system it is expected that future joint forward plans may reflect more fully our wider partnership activities including the role of primary care, social care, public health, voluntary and community groups.

Our aim is that all system partners, and those living in the area, can use this plan to understand how, working together, we can deliver improvements in:

- The health and wellbeing of our people
- The quality of services provided
- The efficiency and sustainability of use of resources

Joint Forward Plan on a Page

Our System Vision and Partnerships 01	Everyone who lives in our area has the best possible start in life, lives happier, healthier lives for longer, and can access the right support when it is needed				
	Place based partnerships, Provider Collaboratives, Clinical Networks, VCSE, Communities				
Addressing Our Biggest System Challenges 02	1. A reduction in inequalities in outcomes and experience 2. People are better supported in their communities to live healthier lives 3. Improved accessibility of our services and elimination of long waits 4. A sustainable model of delivery across the BOB system				
Delivering Our Strategy – Our Service Delivery Plans 03	**Promote and protect health:** Keeping people healthy and well	**Start Well:** Help all children achieve the best start in life	**Live Well:** Support people and communities live healthy and happier lives	**Age Well**: Stay healthy, independent lives for longer	**Quality and access:** Accessing the right care in the best place
	1. Prevention 2. Inequalities 3. Vaccination and Immunisations	1. Maternity 2. Children and Adolescent Mental Health Services 3. Learning Disabilities 4. Children's Neurodiversity 5. Children with Long Term Conditions	1. Long Term Conditions (stroke, cardiovascular disease, diabetes, respiratory) 2. Adult Mental Health 3. Adult Neurodiversity 4. Cancer	1. Ageing well services (e.g., frailty – community multidisciplinary teams)	1. Primary care 2. Urgent and Emergency Care 3. Planned care 4. Palliative and End of Life Care
Supporting and Enabling Delivery 04	Workforce, Finance, Digital, Estates, Research & Innovation, Net Zero, Quality, Personalised Care, Continuing Healthcare				

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Addressing Our Biggest Challenges

	Our Biggest System Challenges	The Outcomes We Want To Achieve	Aligning to the BOB Integrated Care Strategy
Our inequalities challenge	People in certain communities and demographic groups in BOB have **much worse health outcomes and experience**	**Reduction in inequality of access, experience and outcomes** across our population and communities	Promote and Protect healt
Our model of care challenge	We have an **ageing population in BOB and more people living with long term conditions**, who will be increasingly poorly served by an acute-focused model of care	People are supported to **live healthier lives for longer in their communities**	Start, Live and Age well
Our patient experience challenge	People in BOB tell us their **experience of using our services has deteriorated** – driven primarily by long waits and difficulty accessing services	**Improve accessibility of our services and eliminate long waits** to improve citizen experience.	Improving quality and access to services
Our sustainability challenge	We have **a large forecast financial deficit** across our system with **significant workforce gaps**, which is likely to get worse without change	A sustainable model of care in BOB – achieving **financial balance** with a **stable, resilient workforce**	

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2.7. Addressing our Inequalities Challenge

Service Delivery Plans Reference in Full JFP:
- Inequalities & Prevention – p32 - 40
- Maternity and Neonatal – p47 - 50
- Long Term Conditions – p72 - 84
- Personalised care – p159 - 160

Outcome goal: Reduction in inequality of access, experience and outcomes across our population and communities

To reduce inequalities in access, experience and outcomes, we need to have the right data-driven approach to targeting interventions where there is greatest need. In 2023/24 we are therefore committed to building on our existing PHM activity to develop a **Population Health Management Approach, with initial targeted rollout to specific clinical areas,** that will underpin much of the critical work we will do across the system to address inequalities in access, experience and outcomes for our population.
This will allow us to define as a system how we put in the right data infrastructure and capabilities to clearly understand where the areas of greatest inequalities exist, analyse what is causing them, and therefore what we can do that will have the biggest impact on addressing them. This work will underpin and enable a range of initiatives, including those identified through our system workshop:

23/24 "Must Do" - Population Health Management Approach [DRAFT STILL TO BE VALIDATED]

Q1:
- Form an ICS Data Leadership and Governance group to oversee key initiatives
- Establish ICS Data Charter to underpin data sharing

Q2
- Complete stock-take of datasets, collections and reporting across the system
- Establish a Centre of Excellence for Data, including learning and Community of Practice

Q3
- Build a team that can respond rapidly to requests, work with local teams, produce proof of value analysis to support decision making and funding applications
- Agree shared responsibility for key capability between the ICS and local system functions, to make the most effective use of talent across the ICS

Q4
- Define, procure and implement a common ICS data architecture
- Maximise the value of the Secure Data Environment (SDE) for collaboration and innovation

Other initiatives from workshop discussion	Proposed Next Steps	Measuring Success
Increase the allocation of resources to those communities with the greatest need, informed through identification of those communities or groups with the highest deprivation and/or worst outcomes	• Develop a system-wide understanding of those communities with the greatest need through robust data analysis shared across system partners • Design of pathway-specific interventions– ensuring interventions are designed to maximise impact depending on need • Agree principles of resource allocation across system partners based on need (e.g., health inequalities, top slice of budgets, reallocation of existing resources) • Build data resources and capabilities – e.g., produce PCN profiles	• Disproportionate investment to communities with greatest needs • Reduction in variation in GP access and elective care waits • Reduction in variation in LTC rates between most and least deprived pops • Improved health and wellbeing in deprived communities
Implement **multi agency teams as a priority** for those communities with the greatest need – allowing us to provide greater **personalised care and support**	• Use PHM approach to identify those populations with greatest need • Consider existing integrated neighbourhood team plans and how they could be accelerated and enhanced. • Work with VCSE and other system partners to map current offerings, consider physical (co)location with e.g., Citizens Advice • Establish quality improvement / test and learn approach to try interventions and stop or scale	• Engage with 100% of people in greatest need for specified pathways • Reduction in variation in GP access and elective care waits • Reduction in variation in LTCs rates between most and least deprived populations
Improve the health and wellbeing of our workforce who experience the highest levels of inequality (e.g., lower banded and outsourced workforce) across our system	• Identify potential scope of 'target workforce', consider defining small population to start with, develop test and learn approach. • Listen to staff in these groups to understand the improvements we can make that would have the biggest impact • Maximise local impact of our organisations through local employment, training and development • Investment and rollout of top interventions at pace	• Reduction in inequalities measures for the targeted workforce groups • Improvement in wellbeing metrics for defined population

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2.8 Addressing our Model of Care Challenge

Service Delivery Plans Reference in Full JFP:
- Live Well Service Plans– p59-93
- Inequalities & Prevention – p32-40
- Primary Care – p121 - 127
- Planned Care – p116 - 120
- Urgent and Emergency Care – p06 - 115

Outcome goal: People are better supported in their communities to live healthier lives

To support people better in their communities we need to materially change the way our Primary and community care services operate across the system. In 2023/24 we are therefore committed to developing a **Primary Care Strategy** to confirm how we can develop our primary care services in particular to support a more community-focussed model of care that better meets the needs of our population, balancing continuity of care with same day access pressures.
We will collaborate with system partners early 2023/24 to shape and develop this strategy and will ensure it's scope is sufficient to help us make the significant shift in the model of care that we require as a system. This strategy will help us shape our approach to developing some of the proposed initiatives identified through our System workshop, including:

23/24 "Must Do" – Primary Care strategy [DRAFT - STILL TO BE VALIDATED]

Q1:
- Review global best practice and commence structured engagement with stakeholders to agree the vision for Primary Care in BOB.
- Conduct a current state analysis, eliciting any underlying gaps in data, technology and service provision for Primary Care.
- Identify priorities and opportunities to accelerate integrated neighbourhood team rollout

Q2
- Co-design a new Target Operating Model for Primary Care and publish a Primary Care Strategy with a 5-year roadmap for implementation and workstreams agreed.

Q3
- Commence detailed planning and implementation of Target Operating Model focusing on the core areas of focus from the Fuller Stocktake – Access, Continuity and Prevention.

Q4
- Support workstreams to implement the Target Operating Model – particularly with respect to workforce recruitment and retention, technology procurement, finance planning and estates

Other initiatives from workshop discussion	Proposed Next Steps	Measuring Success
Development of a **new community focused model of care**, including a new **model of primary care** and **community 'one stop shops'** with open access for people with multiple conditions	• Establish system group to further scope and agree the scale and nature of transformation required to shift model from acute to community • As part of Primary Care strategy work, scope potential for community "one stop shops", including the strategic estates required to set up, understand the resources available, diagnostics etc.	• Reduction in A&E waiting times • Reduction in unplanned/ emergency care admissions • Increase in patients attending community support groups • Improvement in patient related outcome measures • Resident satisfaction
Development of a **new system approach to co-ordinated care plans** with patients managing own condition with **integration and coordination of community groups**, **VCSE and local organisations**.	• Understand current mapping of services directories at a system-level and conduct gap analysis • Understand patient needs for care plans and current state of integration in primary and community services. • Step-change in joint working across system partners including community groups, VCSE etc. – regular working sessions, co-location of staff etc. • Identify opportunities for digital intervention, establish a system working group with system partners for Right Person, Right Care and develop detailed plans for access to Same Day Care.	• Improved metrics for patient experience • Improved population health management metrics • Improved life expectancy • Preventing and delaying people developing LTCs • Number of people engaging with services
Greater investment in education to self-manage health conditions across the BOB population,.	• Use digital and social media platforms and recognising different requirements for our population groups • Design interventions and support directly with local communities • Understand how we can optimise primary prevention measures • Identify community groups most in need, understand digital resources and platforms available and develop detailed plans with system partners to roll out to key groups.	• Better outcomes for our population e.g., children in school rates, adults in work rates • Reduction in inequality of Life expectancy and healthy life expectancy

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2.9 Addressing our Experience Challenge

Service Delivery Plans Reference in Full JFP:
- Access & Quality Service Plans – p102-127
- Promoting & Protecting Health Service Plans p28 - 41

Outcome goal: Ensuring people can access high quality care and support at the right time and in a place they can get to

Ensuring people can access the right care and support requires us to better understand and utilise the capacity available within the system. To shape our approach to addressing this challenge, in 2023/24 we are committed to working through our **Acute Provider Collaborative** to develop a **System Demand and Capacity Model** that will allow us, as a system, to both understand and baseline current levels of demand and capacity and model how these may change over time. An effective model will allow us to model the impact of our proposed interventions at a system level in a way we have previously been unable to do. This model will help us both assess and prioritise our proposed interventions, as well as evaluate and take forward our proposed initiatives identified through our System workshop:

23/24 "Must Do" – System Demand and Capacity Model [DRAFT - STILL TO BE VALIDATED]

Q1:
- Scoping of model development – define problem statement, potential scope and scale of model
- Understand existing data landscape across system partners

Q2
- Evaluation and decision on tools, methodology.
- Assessment of available resources and how to deploy

Q3
- Model build and deployment
- Baselining of current capacity levels, refinement of model to ensure comprehensive capture of system level capacity

Q4
- Modelling of system interventions to determine likely impact
- Utilisation as strategic planning tool to inform flexible utilisation of system capacity, plan development and prioritisation for 24/25

Other Initiatives from workshop discussion	Next Steps	Measuring Success
Fully **understand our existing system capacity across system partners**, including baselining existing **activity, workforce, and estate** across BOB health and social care provision.	• Shape demand and capacity model work to ensure we can develop a more detailed understanding of the baseline system level capacity across key service areas (including diagnostics, cancer etc.) – where people are currently seen, levels of activity, levels of utilisation • Potential in the short-term to focus on a targeted area to rapidly build/test • Scope benefits of system wide initiatives to manage capacity at system level – e.g., shared patient waiting list	• Evidenced greater flexibility in utilising system capacity – greater utilisation of capacity at system level • Reduction in waiting times for targeted areas following implementation
Support citizens to **understand and navigate our services more effectively**, and increase **co-design of services with patients/carers/communities**	• Build alongside demand and capacity work to develop comprehensive directory of services at system level • Develop communication and engagement approach (e.g., survey following A&E visit to ask for reason for visit) • Develop and agree citizen personas to help us shape service design at a system level, identify core current usage patterns. • Consider focus groups to explore how to shift behaviour • Develop this work alongside established networks such as BOB VCSE Alliance and Health watch	• Improved citizen experience (reports) - e.g., Net Promoter Score, and qualitative data provided through a variety of feedback methods including questionnaires, focus groups • Reduce non-elective admissions • Reduce A&E waiting times
System partners to work together to provide **tailored support to the 10 most deprived areas in BOB, considering appropriate bespoke services**	• Use available data (e.g., A&E, ambulance) to understand the causes of activity from communities with greatest needs • Work with those communities to understand causes and co-design right support • Collaborative work alongside identified community leaders is required to understand needs together • Development of community outreach programmes to encourage better engagement	• Reduce life expectancy gap – use of national benchmarks to determine appropriate % improvement over period. • Reduce attendance at A&E – improvements in % from deprived areas

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2.10 Addressing our Sustainability Challenge

Service Delivery Plans Reference in Full JFP:
- Workforce – See p135-139
- Finance – See p145-148
- Estates – 143 -144
- Net Zero – See p175-176

Outcome goal: A sustainable model of delivery in BOB – achieving financial balance with a stable and resilient workforce

Establishing a sustainable model of delivery in BOB requires major change to the way we work. In 2023/24 we are committed to developing a:
- **System People Plan** – Defining and agreeing our system approach to addressing our workforce challenges and supporting our staff across health and care
- **System Commercial Strategy (CS)** – Defining how our system can more effectively maximise commercial opportunities to support investment in our priorities
- **Drivers of Deficit (DoD) Review**- Understanding the core drivers of our financial position and designing our interventions to most effectively address them

Together, these will shape and support our approach to taking forward our proposed initiatives identified through the System Workshop:

23/24 "Must Dos" [DRAFT - STILL TO BE VALIDATED]

ICS People Plan

Q1:
- Build a comprehensive understanding across system partners of where the key gaps and risk are within our workforce.

Q2
- Deep dive assessments of key workforce issues – e.g., the barriers for successful recruitment campaigns and resourcing, supporting collaborative actions plans.

Q3
- Develop our full People Plan collaboratively with leaders and people across BOB's health and care system.

Q4
- Finalise our People Plan for publication on 1st April 2024.

Drivers of Deficit / Comm Strat.

Q1:
- DoD: Complete drivers of deficit assessment
- CS: Commercial Strategy Group to scope work

Q2
- DoD: Prioritisation of efficiency opportunities and detailed action planning, initial rollout
- CS: Strategy development in partnership, identification of priority initiatives

Q3
- DoD: Rollout of opportunities by level of priority
- CS: Strategy agreement and signoff, strategy mobilisation

Q4
- DoD: Continued rollout of opportunities by priority, ongoing evaluation of success
- CS: Full strategy rollout

Other Initiatives from workshop discussion	Proposed Next Steps	Measuring Success
A **harmonised approach** across the system to **improving the lives of our workforce**	• Listen to staff - understand the actions that would have the greatest impact on improving lives • Understand the resources available and how best to deploy them to deliver the biggest impact • Develop specific plans to rollout top 3 interventions that will make the biggest difference to our workforce • Coordinate our approach across system partners including outside of NHS	• Greater mobility in workforce across system. • Improvements to system workforce retention Reduction in agency by >10% next year • Improvement in staff survey across BOB
New and innovative approaches to **raising and using funding**	• Feasibility assessment of raising external funding • Joint working with VCSE • Set specific fundraising target agreed at system • Define priority programmes to invest ringfenced money in (e.g., transformation fund) • Understand current drivers of deficit and develop plans to address causes within control	• Achievement of external finance target raised next year X% (TBC) of total system budget ringfenced
Greater **investment in prevention activity** across the system	• Understand best practice (e.g., Norfolk) and what is needed to roll-out in BOB • Work with AHSN and Directors of Public Health to identify the top 5 areas for investment • Understand what data currently exists to target interventions • Utilise population health management approach to target those most in need, rollout top 5 interventions	• Replicate Norfolk + Waveney case study → 100% of target group contacts in 10% most deprived areas • 5 pilots launched in next 12 months • Improvement in a minimum of 5 key wellbeing metrics

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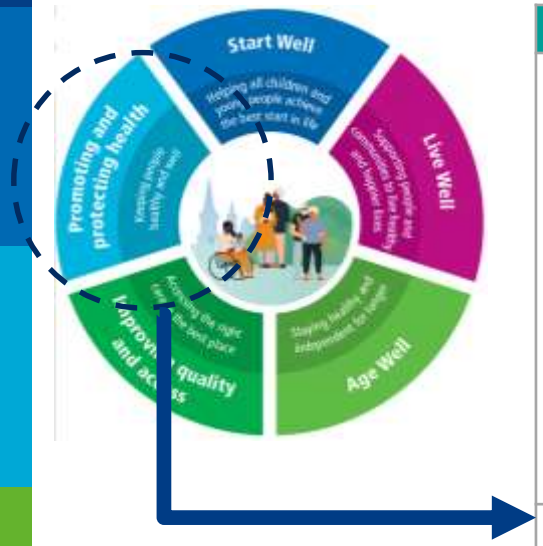
Our Service Delivery Plans (summary of ambitions)

How we will deliver the BOB Integrated Care Strategy and our universal NHS commitments

Delivering Our Strategy – Protecting and Promoting Health



Service Area	Five-year Ambition	Our Delivery Focus
Inequalities	**Reduce health inequalities (access and experience or services & health outcomes) for our population** so that everyone has equal access to appropriate services and support. To enable this, we will provide tailored support to defined populations or groups, particularly those living in deprived areas, certain ethnic groups, LGBTQ+ communities, people with special educational needs and disabilities, people with long-term mental health problems, carers and groups who often are or feel socially excluded.	• Develop an embedded and mature system-wide governance structure, approach and multi agency partnership supporting decision making and delivery • Develop an integrated workforce that is supported and capable to work differently to address inequality in the BOB system • Develop a system wide prioritised, resourced, coordinated and focused approach to Health Inequalities and improving outcomes • Deliver the Core20plus5 priorities
Prevention	**Increase primary and secondary prevention work year-on-year**, keeping people healthy for as long as possible and delaying a deterioration into poor health.	• To enhance engagement, understanding and service provision outcomes for Inclusion Health Groups and populations / areas of inequality • Reduce smoking prevalence • Increase Physical Activity rates for people in BOB • Reduce levels of harmful drinking & drug behaviours and use
Immunisation and Vaccinations	**Protect our population from vaccine preventable diseases** through the implementation of the national immunisation strategy. We will maximise uptake across all vaccination programs, reduce the occurrence of outbreaks while focusing on addressing local vaccine inequalities.	• Develop and deliver a successful population health strategy that supports the reduction in variation of immunisation uptake across our population. • Provide an integrated service that promotes flexibility across providers, meeting the needs of the population resulting in an increase uptake of all immunisation programs. • Develop and maintain a resilient and highly skilled immunisation workforce

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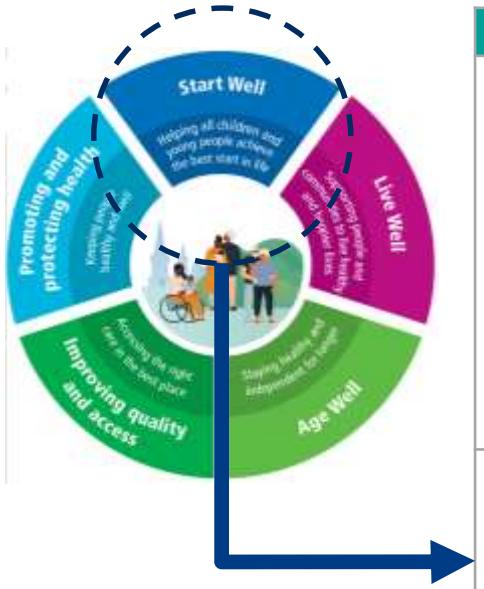
Delivering Our Strategy – Start Well



Service Area	Five-year Ambition	Our Delivery Focus
Maternity and Neonatal	Ensure our maternity and neonatal services in BOB prioritise and provide care which is **safer, equitable, personalised, kinder and sustainable** and ensuring positive work cultures and behaviours.	• **Safety** (learning from incidents and leading on quality improvement initiatives, complying to national maternity and neonatal reviews and schemes, ensuring we use an evidence based, evidence informed approach) • **Workforce** (bolstering supply, enriching roles with up skilling and training, new roles & succession planning, new ways of working, building staff resilience and culture and leadership) • **Personalisation** (improving service user experience of maternity and neonatal services by listening to women and families, engagement and participation, with focus on seldom heard voices from our ethnic diverse and deprived populations, providing personalised care and support plan solutions) • **Prevention and equity** (implementation of BOB maternity and neonatal equity strategy and planning and implementing prevention initiatives and reducing health inequalities for our ethnic diverse and deprived populations) • **Digital and data** (improving accuracy and reliability of data and its use in service and quality improvement, implementing ICB digital strategy)
CYP Mental Health	**Improved mental health and wellbeing outcomes for children and young people** (ages 0 -25), living learning and working in BOB. To achieve this, we will take a needs led and person-centred approach (in line with the thrive framework) to implementation, transformational change and delivery.	• Improve timely access and early intervention to universal care and support across our system • Develop a successful population health approach to supporting those most at risk of mental ill health focussing on early identification, support and prevention • Enhance support for CYP when they experience a mental health crises, developing needs-led models that maximise sustainable community-based solutions
Learning Disabilities	By March 2028, we will have delivered **improved physical, mental health and wellbeing outcomes for children, young people and adults with a learning disability and their families/carers**.	• Reduce health inequalities and ensure that our health and care commissioned services are providing good quality health, care and treatment to people with a learning disability and their families • Improve community-based support • Champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability • Make sure across BOB health and care providers have an awareness of the needs of people with a learning disability
CYP Neurodiversity	By March 2028, we will ensure **that all neuro-divergent children and young people will receive the right support, at the right time and in the right place** dependant on their needs and not dependant on a diagnosis.	• System review of referrals, pre-assessment / assessment & feedback of outcome. Learning and processes are aligned across BOB to improve efficiencies and service user experience • Deliver parity of care across BOB, regardless of a diagnosis of ADHD or autism • Access to timely assessment and diagnosis using alternative models of support for CYP and their families

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Delivering Our Strategy – Live Well

Service Area	Five-year Ambition	Our Delivery Focus
Long term Conditions	• Improve outcomes in population health and healthcare • Act sooner to help those with preventable long-term conditions • Support people with LTCs to stay well & independent • Provide quality care for those with multiple needs as population ages • Co produce consistent pathways across ICS to reduce unwarranted variation • Integrate service models to delivered joined up care wrapped around patients needs	• Assess the population needs, increase preventative interventions, diagnose earlier, reduce inequalities and improve health outcomes • Take a collaborative approach with our partners and stakeholders through the LTC BOB Integrated Delivery Networks (IDNs) to develop integrated care models to better manage patients with LTCs • Develop a proactive approach to improve outcomes for patients with multiple LTCs
Cardiovascular	Reduce the number of CVD events by having a strong focus on prevention, and reduce the health inequality gap by using PHM approach. We aim to **co-design consistent and integrated pathways and empower patients to live well with CVD** and other co-morbidities.	• CVD Prevention – better blood pressure and lipid management • Heart Failure – earlier detection and a reduction in hospital admissions and re-admissions • Enhanced Cardiac Rehabilitation
Respiratory	**Patient-centred, integrated clinical pathways delivering high quality respiratory care that is accessible** to all across BOB ICS Supporting people with respiratory disease to live longer.	• Population health management to identify and support people at most risk • Delivering earlier diagnosis, education and care planning in the community • Integration of respiratory services, enabling the right support to people close to home • Optimising medicines to improve health outcomes and reduce carbon emissions • Leveraging innovation and research to improve outcomes in respiratory care
Stroke	We will bring key stakeholders together to facilitate a **collaborative approach to service improvement of the whole stroke pathway**, including prevention, ensuring a patient centred, evidence-based approach to delivering transformational change.	• Implementing consistent pathways of care for stroke • Maximising stroke prevention opportunities • Reducing variation in access to stroke rehabilitation services
Cancer	**Reduction of the cancer backlog and consistent delivery of the Faster Diagnosis Standard** by March 2024. Sustainably meet all Cancer Waiting Times by March 2028, and achieve the National Cancer Ambition of diagnosing 75% of cancers at Stage I & II	• Delivery of Sustainable operational performance across the system • Delivery of the 28 day Faster Diagnosis standards • Achieve the Early Diagnosis standard • Increase the Early Diagnosis Rates • Improve the quality of treatment and care • Implementation of the Teenage and Young Adult Cancer Care Service Specification • Patient Engagement, Involvement and Experience • Support, Training & Education for medical, nursing, allied health professionals and admin staff in cancer services and primary care

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Delivering Our Strategy – Live Well

Service Area	Five-year Ambition	Our Delivery Focus
Neurodiversity (Adults)	BOB will be an area where Neurodivergent people thrive, and their strengths are embraced	• Improving access to assessing, understanding and supporting a person's neurodiversity • Ensuring infrastructures are in place and are effective to reduce unnecessary admissions under the MHA • Improving the experience for any neurodiverse people using our Mental Health Inpatient Services • Improving equity of access through anticipatory and reasonable adjustments • Ensuring that staff working across BOB have the skills and knowledge to identify Neurodiversity. Understand and meet the needs of this service user group • Co-producing community-based assets that support the social and emotional needs of neurodivergent people
Adult Mental Health	**Improved mental health and wellbeing outcomes for all adults and older people** living, learning and working in BOB.	• Promoting a successful population health approach to identify and support individuals, groups and communities most at risk of developing mental ill health • Tackle the social factors impacting mental health and wellbeing • Improving timely access to support for mental health crises and develop alternative sustainable models • Improving outcomes that are person centred, using asset based approaches that builds resilient communities and promotes integration

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Delivering Our Strategy – Age Well

Service Area	Five-year Ambition	Our Delivery Focus
Age Well Services	By March 2028, we will be: • Supporting more people to remain healthy and independent for longer • Providing **proactive, personalised and coordinated care for more people who are becoming frail** and their health conditions more complex • Supporting more unpaid carers.	• Support people to remain healthy, independent, and connected within their communities. • Offer proactive personalised care planning and identify early those who are likely to develop more complex needs and become frail. • Provide multi-disciplinary integrated care involving health care, social care and VCSE for people as their conditions become more complex and they become frail. Care is coordinated and delivered in the right place at the right time. • Provide rapid reablement and recovery support for people who have become acutely unwell to enable them to return home quickly and safely from hospital. • Identify and support unpaid carers to maintain their own health and wellbeing and their ability to care for their friends and relatives. Inform and empower patients and carers in relation to services and pathways across the system.

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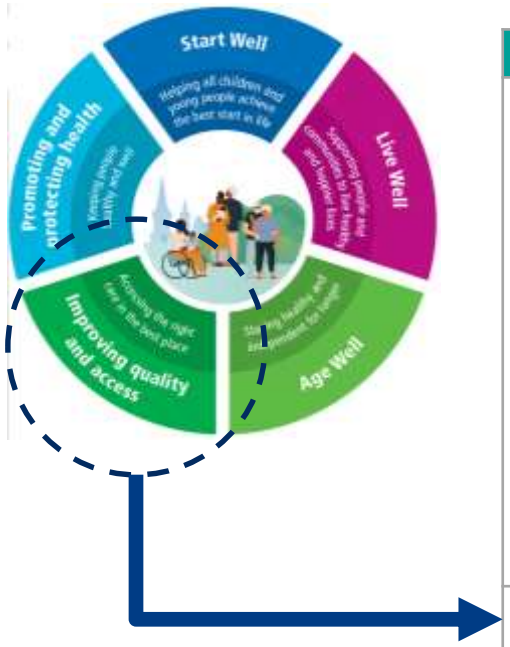
Delivering Our Strategy – Improving Quality and Access



Service Area	Five-year Ambition	Our Delivery Focus
Urgent and Emergency Care	By 2028, our ambition is to ensure we get patients **the right access to the right care when it's needed, improving the outcomes and the experience of patients, their families and friends** and consistently delivery against the operational standards determined by NHSE	• Recover key performance indicators; reducing ambulance handover delays, securing a reduction in the percentage of patients waiting more than 12hrs in Emergency Departments to be seen, improving type 1 A&E performance and; reducing G&A bed occupancy • Develop and implement a model of care that better supports and meets the needs of High Frequency Users, building on the anticipatory care models adopted in primary and community care services • Deliver a consistent single Integrated Urgent Care model across the BOB footprint from September 2024 • Embed and increase the capacity and service offer of Urgent Community Response teams to provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently • Increase adult and paediatric Virtual Ward capacity • Ensure there is a clear route of access to same day services through a Single Point of Access supported by a directory of services that is available to healthcare professionals to inform the timely navigation of pathways • Implementation of the top 10 high impact changes to improve hospital discharge, including from community and Mental Health inpatient services • Secure a non emergency patient transport service that provides a more consistently responsive service, fair access to service users, is sustainable and compliant with the national framework
Planned Care	By March 2028 we will aim to **sustainably reduce and eliminate long waits for our elective services and address variation in access across the system,** recovering to at least pre-pandemic planned care performance levels against NHS Constitutional Standards by March 2028. We aim to improve access to services by enhancing pathways and coordinating approaches across the system, reducing variation and non value-added interventions.	• Increase health service capacity, through the expansion and separation of elective and diagnostic service capacity. • Prioritise diagnosis and treatment, including a return towards delivery of the six-week diagnostic standard and reducing the maximum length of time that patients wait for elective care and treatment. • Transform the way we provide elective care including reforming the way we deliver outpatient appointments, making it more flexible for patients and driven by a focus on clinical risk and need, and increasing activity through dedicated and protected surgical pathways. • Provide better information and support to patients, supported by better data and information to help inform patient decisions.

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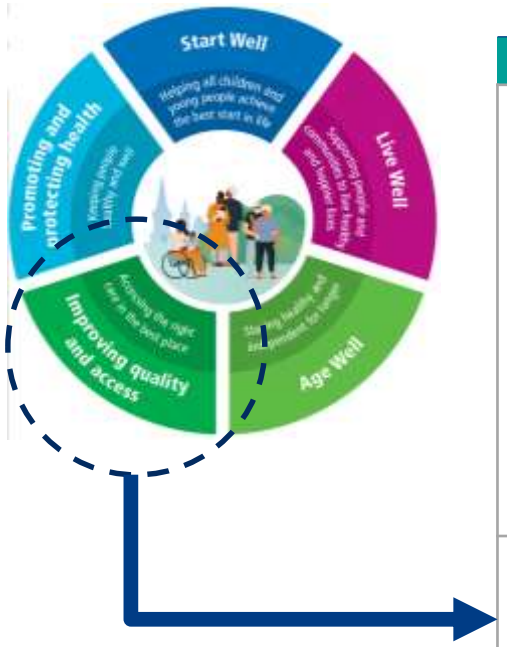
Delivering Our Strategy – Improving Quality and Access



Service Area	Five-year Ambition	Our Delivery Focus
Primary Care	To transform how primary care is delivered in each community/neighbourhood, enabling integrated primary care provision which **improves the access, experience and outcomes for communities aligned to their needs**. Through the mobilisation of integrated neighbourhood health and care teams, primary care services will become more sustainable and patients will get the support they need when they need it.	• Increase primary care resilience and provide the tools required to enable change including time and skills • Create the infrastructure across BOB to implement the change (Estates, Workforce & digital) • Increase capacity and manage demand for primary care services by working differently so that we can deliver on nationally agreed access priorities and targets • Build GP led, integrated neighbourhood teams, supported by a sustainable workforce plan • Deliver more targeted activity to identify and support the prevention of ill-health and address inequalities
Palliative and End of Life Care	We will **deliver high quality, personalised, integrated 24/7 services shaped by those with lived experience for Palliative and End of Life Care** (PEoLC) for all ages, across the BOB ICS.	• A robust model of access to 24/7 Palliative and End of Life services for patients, their carers and relatives • A successful population health approach to early identify people needing Palliative and End of Life services • To co-design PEoLC through Provider Collaboratives and in partnership with people with lived experience.

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Delivering Our Strategy – Enabling Success

Enabled Through

Service Area	Five-year Ambition	Our Delivery Focus
Workforce	By March 2028 we will have an **integrated workforce that is looked after, feels valued and respected, is reflective of our communities** and made up of the right people in the right roles at the right time delivering health and care services for our communities.	• Have an inclusive & diverse compassionate leadership reflecting the population we serve driving cultural change towards strong system partnership working • Improve recruitment and retention through a collaborative focus on strategic workforce planning and developing innovative attraction action plans to support key areas of workforce shortages. • Support a system focus on innovative job design for roles and teams that operate across organisational and professional boundaries, reducing reliance on costly agency workers, and fostering career development through developing meaningful and personalised career pathways • Make Buckinghamshire, Oxfordshire and Berkshire a great place to work in health and care. We will ensure our people have rewarding jobs, work in a positive culture that embraces kindness, civility and respect and are supported with both their physical and mental health and wellbeing.
Digital and Data	Improve the lives and experiences of those accessing and working in our Integrated Care System, through building collective digital and data maturity across our partners and providers. By 2025, we will have: • **Enabled safe and informed care** by aligning our providers behind a single shared care record • **Improved maturity of electronic patient records** by converging providers onto platforms which meet national data standards • **Equipped our workforce** in exploiting the use of digital and data, and develop DDaT professions across the ICS • **Empowered citizens** achieving common digital experiences to enable self management of care and reduce administrative burdens • **Enabled access and care at home** by delivering capabilities such as virtual wards, virtual consultations and remote monitoring • **Provided common infrastructure** enabling staff mobility, and optimise performance, resilience and security of systems, while delivering VfM • **Delivered our data foundations** to improve data flows across the ICS enabling more informed decisions	• Digitise our providers to reach the Minimum Digital Foundations to reach a core level of digitisation across our system • Connect our care setting using digital, data and technology and improve citizen experience • Transform our data foundations to provide the insights required to transform our system and better meet the needs of our population
Quality	It is our ambition that **"Each patient will receive timely, safe, effective care with a positive experience."** We will demonstrate this by delivering on our Quality Strategy and improving against comprehensive system metrics and our CQC and SOF ratings	• Publish a Quality Strategy to support improvement which will incorporate the National Patient Safety Strategy. • Develop a system-wide quality assurance framework to underpin our improvement work, based on the NHSE early warning metrics for systems • Ensure patient experience and co-design is fully embedded in our quality assurance/improvement work and our quality strategy

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